MassHealth

Commonwealth of Massachusetts
EOHHS

Status Change for a Member in a Long Term Care Facility or Rest Home
(Admission or Discharge of MassHealth Member or SSI Recipient)

1. Date	REG	MEC	Coverage type	Member's last name	First name	MI

2. Name of facility submitting this notification	Address	Telephone

3. Provider number	**4.** Admit date	**5.** MassHealth request date

6. ☐ A–Admit ☐ D–Discharge ☐ R–Both admit and discharge	**7.** Member's ID/SSN

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8. PPA Amount	Effective Date (MM/YY)	Retro PPA ☐
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9. Level of Care	**10.** MassHealth Start Date
11. Discharge Reason	**12.** Worker CAN

13. Discharge Date	**14.** Date of Death	**15.** Comments

Check all appropriate boxes:

16. **A. Short term (6 months or less)** ☐
B. Long term (more than 6 months) ☐
C. Short-term-care stay terminated; now long-term care ☐
D. Medicare upon admission ☐
E. SCO (NF screening-notification form not needed) ☐

17. Admitted from	**18**. Discharged to

Complete items 19 and 20 only if member's expected stay is six months or less.

19. **I certify that the above-named member's expected length of stay is**

20. **Physician's signature**	**Date**

21. **Signature of authorized representative completing this form**	**Date**

NOTE: Nursing-facility screening-notification form or admission-determination letter must be attached.

SEE REVERSE SIDE FOR INSTRUCTIONS FOR COMPLETING THIS FORM.

Instructions to Long Term Care Providers

The following instructions correspond to numbered items on the reverse side. Please Note: For SSI recipients, a copy of the SC-1 must be sent to the appropriate Social Security District Office.

1. Enter today's date, the member's region, MassHealth Enrollment Center, MassHealth coverage type, and name (please print).

2. Enter the name, address, and telephone number of the facility submitting this form.

3. Enter the seven-digit provider number.

4. Enter the date of admission.

5. Enter the date from which MassHealth payment is requested.

6. Enter the appropriate code: **A for admitted, D for discharged, or R** for both admitted and discharged.

7. Enter the member's 10-digit MassHealth identification number, if known.

ITEMS 8 THROUGH 12 ARE FOR INTERNAL MASSHEALTH USE ONLY.

13. Enter the discharge date for the current discharge and if both admitting and discharging.

14. Enter the date of death, if applicable.

15. Use this space to enter any comments.

16. Check box 16A to indicate a short-term stay (six months or less), 16B to indicate a long-term stay, or 16C to indicate that the short-term stay is terminated and is now long term. Check 16D if the member is Medicare eligible upon admission. Check 16E if the member is admitted to nursing facility under SCO (nursing-facility screening-notification form not needed).

17. Enter where member is admitted from (i.e., home, name of acute or chronic hospital).

18. Enter where member is discharged to (i.e., home, name and address of acute or chronic hospital).

19. Enter the expected length of stay **only if the expected stay is six months or less**.

20. The physician must sign and date **only if the expected stay is six months or less**. For a long-term stay, no signature is required.

21. An authorized representative of the facility must sign and date this form.